minous. Up to the time of death consciousness was retained, and the cardiac sounds maintained their purity. At the necropsy, ulcerative endocarditis of the left side was found, along with a large clot attached to the wall of the auricle, and prolonged into the ventricle, where it was adherent to the chordæ tendineæ. The auriculo-ventricular valve was perforated; the aortic competent, but inflamed. At the bifurcation of the aorta there was a large fibrinous clot, not adherent to the vessel. The spinal meninges and the cord itself were much congested in the lumbar region, the kidneys were studded with infarcts, the spleen congested, and its main artery obliterated; there were no signs of embolism in the brain, the lungs, or the liver. The authors cite several cases of aortic embolism and thrombosis, and point out that the former is more frequently met with than the latter. To explain why there was no murmur in their case, when the clot would be expected to produce one, MM. Barie and Du Castel, under the supervision of M. Potain, arranged a series of tubes of the same calibre, through which currents of water (at the same pressure) flowed. In these tubes were placed diaphragms of the same metal, perforated by apertures of different shape and position. They found that the intensity of the murmur was the same in all, whatever the form and situation of the orifice might be. Then to make out whether the material of which the obstacles were composed had any influence, they removed the diaphragms, and substituted foreign bodies of different nature and resistance. The murmur was loud and distinct when the obstacle was hard and resistant; but when it was soft and velvety the murmur almost disappeared. They therefore conclude: 1. That the form of the orifice has no influence over the production of the murmur; 2. That the consistence of the walls of the orifice exerts a notable influence upon the intensity of the murmur.—*London Med. Record*, Dec. 1881.

Œsophageal Ulcer from Digestion.

Professor QUINCKE, of Kiel, published some time since observations to show that ulcers may occur in the œsophagus from the action of the gastric juice. Three cases are now (*Deut. Archiv für Klin. Med.*) published in support of this. 1. The first case was that of a patient suffering from cancer of both ovaries. The ulcer was in the lower part of the œsophagus; and in this, as in the other cases, the absence of cancer at the spot was proved by microscopic examination, as was also the possibility of corrosion *ante mortem* or digestion *post mortem*. 2. The second was that of a patient affected with ovarian cyst, in whom an œsophageal ulcer in the lower half had perforated into the right pleural cavity. 3. The third case was that of a man, 50 years of age, cachectic, and to all appearance suffering from cancer. The *post-mortem* examination, however, showed the cause to be marked narrowing of the œsophageal opening of the stomach by a cicatricial stricture, evidently the remains of a previous ulcer involving the neighbouring mucous membrane, and giving rise to muscular hypertrophy of the œsophagus and chronic swelling of its mucous membrane.—*London Med. Record*, December 15, 1881.

Encysted Dropsy of the Peritoneum.

At the meeting of the Harveian Society of London, on Jan. 5, Mr. KNOWSLEY THORNTON read a paper on this subject. The disease is very rare, but he had met with two cases in his hospital practice in the last three months, and this showed that we must be prepared to diagnose it from other abdominal enlargements. Correct diagnosis being all important in these cases for successful treatment, he alluded to the small amount of information on the subject to be found in either the general or special text-books. He quoted at some length a case in Mr. Spencer Wells's work on Diseases of the Ovaries, which very closely resembled one of his own, and alluded to the opinions of Drs. West and Peaslee. The statements of the latter he regarded as misleading, the errors arising, in his opinion, from an attempt to generalize from imperfect data. He pointed out that it is important to distinguish this disease from the much commoner condition in which partial collections of fluid occur in the peritoneum around malignant growths. His own cases were then fully recorded.

Case 1 was that of a woman of forty-five, supposed to have an ovarian tumour, which was also supposed to have ruptured into the peritoneum while she was under the author's observation. Suppression of urine led to tapping of the peritoneum, which gave temporary relief, but she died with uræmic symptoms without further operation. The post-mortem revealed very advanced granular disease of the kidneys, a large spleen, and an encysted dropsy which had become general by breaking down adhesions. The ovaries were healthy.

Case 2 was that of a young girl in whose abdomen a doubtful collection of fluid existed. It was a very difficult case for diagnosis, but, on the whole, the author leaned to the view that it was a case of flaccid broad ligament cyst. Abdominal section showed that it was an encysted dropsy of the peritoneum. The fluid was removed, the sac carefully sponged out, and the incision closed without drainage. The patient made a good recovery, the intestines gradually re-occupying the place where the fluid had been, and when she was last seen there was no appearance of re-accumulation.

Mr. Thornton urged the importance of the record of rare cases, and pointed out that the knowledge of this disease was still too limited for it to be possible to lay down rules as to diagnosis. He would accept Peaslee's statement that encysted dropsy of the peritoneum is always preceded and caused by peritonitis. The causes of the peritonitis are, however, very various. With regard to treatment, he thought it right to open the abdomen, and sponge out the sac, in any case in which the condition was diagnosed in a patient free from kidney disease; drainage was not necessary. He urged the advantage of incision as compared with tapping, and spoke strongly as to the value of Listerism in abdominal section, emphasizing his faith by his results in ovariotomy at the Samaritan Hospital in 1881. During that year he had had forty-one cases, had not once drained, and had only two deaths, both occurring in young patients, the subjects of malignant tumour.—*Lancet*, Jan. 21, 1882.

Malaria and Diabetes.

At the meeting of the *Académie de Médecine* on November 29th, M. Verneuil communicated six observations that he had made within the year, relative to surgical affections in persons affected simultaneously with glycosuria and malaria, and he presented an extended historical review of the authors who had previously noted this association of diseases. He cited in particular the memoir of Dr. Burdel, presented to the *Académie des Sciences* in 1859, of which the following were the conclusions: 1. There exists a true diabetes in malaria. 2. This diabetes is only ephemeral, that is to say, it appears with the fever, lasts during its stay, and disappears with it. 3. The glycosuria of malarial fever reveals the disturbance which destroys the equilibrium between the cerebro-spinal and sympathetic nervous systems. 4. This explanation, given by Claude Bernard, is confirmed by the clinical facts. 5. The more violent the cases, and intense the fever, the greater the quantity of sugar in the urine. 6. When, on the contrary,